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Regulation of advanced nurse practitioners: understanding the current- processes in the UK

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Abstract

The UK National Health Service (NHS) is currently under increasing pressure due to financial and recruitment problems, as well as our increasing aging population. Nursing has continued to adapt its role to meet the needs of these challenging times. Over the last few years the Advanced Nurse Practitioner (ANP) role has been implemented widely in both primary and secondary care. However these roles have lacked consistency in scope of practice, training and regulation. This paper summarises the development of the ANP role in the UK and internationally, and current issues around regulation. Globally ANPs are regulated by one of three different mechanisms, nationally by central government or a professional body, or locally by employers. In the UK the role is regulated by local procedures, relying on employers to make decisions about the scope and preparation for practice. Some of the challenges of the UK position in relation to ANP regulation will be discussed, including variations in scope, organisational constraints, and lack of support. It has been suggested that these challenges are exacerbated by a lack of role clarity, therefore highlighting a need to improve regulation of ANPs. The RCN has moved some way to responding to these challenges by introducing 'credentialing'; a system for recording qualifications, skills and experience, but the uptake of this is yet to be evaluated. This review highlights that employers and ANPs need to be aware of their collective responsibility for ensuring appropriate role regulation.

Introduction

This paper reflects on the potential contribution of regulation of advanced nurse practitioners (ANPs) in professional nursing practice in the UK. National regulation of ANPs has been repeatedly discussed since these roles first emerged, but this has never been implemented. However, the recent introduction of credentialing by the Royal College of Nursing (RCN) (2017) has prompted a rethink of regulation of ANPs.

This article has been prompted by the author's experience as an ANP in primary care, as well as observations and discussions she has had whilst conducting a doctoral study. The author's PhD is examining discharge decision-making by ANPs in emergency care. The paper is not based on the PhD data; it is based on findings from a narrative literature review, discussions with clinicians and recent debates in the nursing press (Heale and Rieck Buckley, 2015, Maclaine, 2017, Pearce, 2017).

Advanced Nurse Practitioner roles

The UK healthcare service is reaching capacity and emergency departments have been described as 'close to tipping point' (Evans, 2016). In these times of scarce resources the nursing profession has continued to adapt to meet local demands. One response has been the increase in ANP roles (Sheer and Wong, 2008). ANPs have been defined as 'registered nurses who have acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice' (International Council of Nurses, 2002). The RCN adds that ANPs are 'educated at master's level.... and have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis and treatment of patients' (Royal College of Nursing, 2017).

This paper summarises the variations in the scope of the ANP role, and discusses the need for clarity of titles, training and regulation. National regulation of ANPs has been a topic of debate amongst policy makers in the UK for the past 20 years. The current system in the UK relies on employers taking responsibility for ANP regulation, from initial workforce planning, to providing education, role clarity and supervision. At a time when regulation of all UK healthcare workers is being reviewed (Professional Standards Authority, 2016) this is a prime opportunity to consider the challenges to the current employment processes and reconsider national regulation, in line with many other countries (Sheer and Wong, 2008).

Narrative review

A narrative literature review was undertaken in November 2016 and updated in July 2017 to explore what has been written regarding regulation of ANP roles. Narrative reviews have been described as offering a snapshot of prevalent knowledge at a particular point in time (Booth et al., 2016). The aim of this review was to understand

current processes of regulation in the UK. CINAHL and MEDLINE databases were searched using 'regulation' and 'advanced nurse practitioner' as keywords. Articles published from 2001 to the present day were identified. Reference lists were scanned for further relevant articles. The papers were appraised by searching the titles, and then the full articles for discussions about the regulation of advanced nurse practitioners globally. Relevant grey literature was also reviewed from the Nursing and Midwifery Council, Royal College of Nursing, Royal College of Emergency Medicine, Department of Health, NHS England, and NHS Scotland.

The development of ANP roles

Over the past few years there has been a political drive to provide more cost-effective healthcare, leading to an increase in the expansion of non-medical roles (Abraham et al., 2016). This is accompanied by a desire by nurses to further their careers by increasing their knowledge and clinical skills.

The ANP role was first introduced in the United States of America (USA) and Canada in the mid-1960s, followed by the UK in the mid-1980s, then New Zealand and Australia in the 1990s (Pearson and Peels, 2002a, Furlong and Smith, 2005, Griffin and Melby, 2006). Many factors influenced the introduction of ANP roles worldwide, including a shortage of doctors, a need to improve access to primary care, to improve care for particular patient groups, government policy, inter/ intra-professional collaboration, nurse education and positive evaluations of the role (Ketefian et al., 2001, Schober and Affara, 2006). In the UK factors influencing the development of the ANP role included a need to reduce healthcare costs, to improve access to healthcare and to respond to the reduced availability of doctors (Pearson and Peels, 2002a). ANPs in the USA and UK were first employed in primary care to ease the workload of doctors, however they are now more prevalent in secondary care (Pulcini et al., 2010). Early policy drivers of ANP role development in the UK included a proposed redesign of the health service outlined in 'the NHS plan', aiming to provide flexible services and to end the fixed boundaries between doctors and other health professionals (Department of Health, 2000).

Several studies have explored the effectiveness of the ANP role. Williamson et al (2012) performed a ward based ethnographic study of ANPs and found they enhanced communication and practice, facilitating the patient journey. In research

using a case study approach to explore ANP roles McDonnell et al (2015) concluded that ANPs have a positive impact on patients, other staff and organisational outcomes. In a survey study Griffin and Melby (2006) examined the perceptions of nurses and doctors of the ANP role. They found the role was generally viewed positively, however less so by GPs. They suggested that multidisciplinary acceptance would be improved by accredited, standardised ANP training.

Since implementation, there has been much ambiguity about advanced nursing titles. A survey of 32 countries identified 13 different titles including; nurse practitioner, advanced practice nurse, clinical nurse specialist, nurse specialist, professional nurse, expert nurse, and nurse consultant (Pulcini et al., 2010). In this paper the umbrella term ANP is utilised to describe advanced nursing roles (Royal College of Nursing, 2012). Despite many recommendations for standardisation of role and educational preparation, there remains confusion and wide variation in using the ANP title (Pearson and Peels, 2002b, Marsden et al., 2003, Furlong and Smith, 2005, Hoskins, 2012); however a summary of key features of the ANP role is given below.

ANP scope of practice

Scope of practice describes the role to be undertaken, including knowledge, attitudes and skills required by the practitioner, as well as mechanisms of accountability (Schober and Affara, 2006). The ANP role varies globally, depending on the particular healthcare needs of the population, however it commonly includes roles that were traditionally undertaken by physicians (Schober and Affara, 2006, Heale and Rieck Buckley, 2015). In the UK the ANP role involves practicing autonomously, taking a patient history, using advanced clinical skills to assess, order and interpret tests, diagnose, and decide on the most appropriate management, including prescribing medicines (Latter et al., 2007, Department of Health, 2010a, Brook and Rushforth, 2011). In an earlier literature review (Mantzoukas and Watkinson, 2007) key themes related to the ANP role were outlined and include; the use of knowledge in practice, critical thinking and analytical skills, clinical judgement and decision-making.

ANPs work in a wide range of healthcare settings. For example in ophthalmology they provide emergency care, perform minor surgery and run glaucoma clinics

(Marsden et al., 2013). In emergency departments ANPs take a history, perform a physical examination, order and interpret relevant tests, prescribe treatments and discharge or refer patients (Fawdon and Adams, 2013).

One study found the variation of scope to be related to individual competence and the preferences of medical colleagues (Maddox et al., 2016). Jones (2005) argues that clear role definitions and expectations are important to the success of the ANP role. Although previous literature has identified wide variations in scope of practice, this discussion is focusing on those roles with significant overlap with medicine, suggested that improving role regulation would provide further clarity to some of these issues. The next section will discuss how ANPs are trained for their expanded scope of practice.

The Four Pillars

In referring to advanced practice the term 'level' of practice' rather than the 'scope' is used (Royal College of Nursing, 2012). 'Advanced practice should be viewed as a 'level of practice' rather than a specific role and it is not exclusively characterised by the clinical domain but may also include those working in research, education, management/ leadership roles p10' (NHS Wales, 2010).

NHS Scotland (2010) outlined four key characteristics of the ANP role; clinical practice, leadership, education and research. This was adapted to devise a framework for advanced practice incorporating four pillars (NHS Wales, 2010). Each pillar, or characteristics of the ANP role, will be evident in different degrees for each individual ANP. However, it is argued that they are all essential to advanced practice (Royal College of Nursing, 2012).

Educational preparation

Educational preparation of ANPs differs between countries and within the UK, with programmes being developed independently of each other (Griffin and Melby, 2006, Schober and Affara, 2006, Heale and Rieck Buckley, 2015). Master's level preparation is a minimum standard for ANP roles in many countries. However, although there is a consensus among the UK health departments that Master's level education will be expected in the future (Royal College of Nursing, 2012), this is not currently the case (Schober and Affara, 2006, Pulcini et al., 2010). A survey found that under one third of ANPs in the UK had a Master's degree (Gerrish et al., 2011).

It should be noted that some pre-registration nursing courses in the UK now include more advanced skills in their content, particularly those at master's level, leading to a blurring of the academic boundaries between junior and advanced nurses. It is here that the value of nursing experience should also be taken into consideration when appointing nurses to ANP positions (Benner, 1984).

The Department of Health (2010a) has outlined a number of competencies for ANPs, including critical thinking, applying knowledge and skills to a broad range of clinically and professionally challenging situations, and working across professional boundaries. These guidelines are very broad, and are open to interpretation by nurses, employers, and educators in a variety of ways. The RCN (2012) has designed a framework of standards and competencies which Higher Educational Institutions (HEIs) may use to develop educational programmes for ANPs. Nurses who complete such accredited programmes can receive a certificate from the RCN. However this training is not a requirement for all ANP practice, and not all nurses are members of the RCN.

Some clinical specialities have taken matters into their own hands in the UK and developed bespoke training courses. For example the Royal College of Emergency Medicine (RCEM) (2015) has developed a training programme for Advanced Clinical Practitioners (ACPs), aimed at training advanced nurses and paramedics in emergency care. The course involves showing proficiency in a wide range of competencies, which are assessed locally by a medical consultant supervisor, followed by a final external assessment. This scheme, although supported by the RCN, is regulated by the medical profession. It is not a requirement of all ANPs in all emergency departments. This raises the question of who should oversee the regulation of ANPs, should it be governed nationally, by nursing or medical professional bodies, employers, or individuals?

Current UK regulation procedures

The International Council of Nurses (2002) recommend regulation of the ANP role, however there is widespread variation in the processes. Surveys exploring regulation of ANP roles internationally have identified three main areas; government regulation, professional body regulation, or local regulation by employers (Heale and Rieck Buckley, 2015, Maier, 2015). Many countries require national regulation of ANP

titles, scope of practice and registration, including Ireland, the Netherlands, Australia, Canada and the USA (Maier, 2015). The UK and Finland have adopted a mechanism of local governance of the ANP role by employers, however they do nationally regulate prescriptive authority (Maier, 2015). It has been argued that the lack of national role regulation in the UK has added to the wide discrepancy in practice, difficulty in role clarity, and problems in tracking workforce data, especially as ANP roles are developing opportunistically (Maier, 2015). However NHS Scotland (2010) argue that a change to adopt a more formalised regulation is not necessary. They maintain that advanced practice merely reflects the next step on the nursing career ladder.

NHS Wales (2010) states that organisations should ensure robust governance arrangements are in place prior to establishing ANP roles, surrounding all types and levels of practice. Similarly the RCN (2012) highlights that improving employer-led governance is key to providing guidance to ANPs and ensuring patient safety. They state that they are opposed to the use of the ANP title where a nurse has not completed the appropriate educational preparation (Royal College of Nursing, 2012). Similarly the NMC (2007) outlined its concerns about the confusion resulting from the many advanced nursing job titles, many of which may imply a level of knowledge and competence not possessed by the nurse. They have recently implemented a process of revalidation which must be undertaken by all registered nurses every three years (Nursing and Midwifery Council, 2015a). Revalidation requires registrants to prove they are meeting the standards identified in the NMC code of practice (2015b). The requirements for revalidation are 450 practice hours (or 900 if you are a practicing nurse and midwife), 35 hours of continuing professional development, five pieces of practice related feedback, five reflective accounts, and a reflective discussion. There is also a health and character declaration and finally an interview with a confirmer (Nursing and Midwifery Council, 2015a). Revalidation may improve local ANP regulation as it requires the registrant to have a reflective discussion with a clinical supervisor, providing opportunities to highlight learning needs.

The RCN have recently introduced 'credentialing' for ANPs; a system where ANPs can formally log their experience, competence and qualifications (Royal College of Nursing, 2017). Reasons for introducing credentialing were to provide formal

recognition of ANPs' skills and experience, for ANPs, employers, colleagues and the public (Royal College of Nursing, 2017) This new process has been piloted in two phases to test the assessment criteria and was rolled out nationally in Spring 2017 (Pearce, 2017). The requirements for credentialing are outlined in the table 1 below:

Table 1

<i>ANP credentialing requirements</i>
A relevant Master's qualification
An independent non-medical prescribing qualification registered with the NMC
An active member of the NMC
A relevant job plan which reflects the four pillars of advanced level practice: clinical practice, leadership, education and research.

(Royal College of Nursing, 2017)

There will be a transitional period until 2020 where nurses who do not meet all of the above criteria may still meet the credentials by submitting a portfolio of evidence. Those who meet the standard are then put on a publicly available list of ANPs (Royal College of Nursing, 2017). This process of credentialing is voluntary so although it will identify those who *are* meeting the RCN's requirements of advanced practice, it will not mean that those who are not listed are not meeting the requirements. This still leaves the ANP title open to misuse and confusion. The current NMC governance procedures require nurses to adhere to the NMC code (2015b) by both employer and self-governance. The introduction of credentialing, although voluntary, could be seen as a step towards a more structured and formalised process of regulation of the expanded roles and responsibilities of ANPs (Pearce, 2017). Some would argue that national regulation would provide further clarity to the required educational standards, scope of practice and titles (Brook and Rushforth, 2011, Carney, 2016)

What about compulsory national regulation?

A recent review of the similarities and differences of international regulation of ANPs found that national regulation occurs in Ireland, Japan, New Zealand, Singapore, Hong Kong, Australia, and the USA, but not in the UK (Carney, 2016). This raises the question of why the UK has not followed suit. Brook and Rushforth (2011) argue that UK national regulation of the ANP role is crucial for public protection due to the high risk nature of the diagnostic aspect of the role. They state that the public should

expect similar regulated standards as medicine, from nurses performing advanced autonomous roles, especially as all doctors are required to meet minimum standards of education, regulated by the General Medical Council (2011).

A report by the Council for Healthcare Regulatory Excellence (CHRE) (2009) defended the decision not to introduce national regulation of the ANP role on the basis of it being an extension of the skills assessed at initial nurse registration. However there is a counter argument that the role has changed significantly in recent years in the UK. There is increasing and considerable overlap with the medical profession and thus the argument against national regulation is weakened. The report goes on to suggest that national regulation should be considered if the risks to patients differs from those ordinarily associated with the profession (Council for Healthcare Regulatory Excellence, 2009). From the review it is possible to suggest that the ANP role is different to other advanced and traditional nursing roles because of the nature of its expanded scope (Brook and Rushforth, 2011). This includes, assessing, diagnosing and treating undifferentiated conditions (Fawdon and Adams, 2013). For some this supports a stronger argument for national regulation and may partly explain why RCN have adopted the credentialing approach (Royal College of Nursing, 2017). However the NMC and CHRE appear to remain unconvinced that regulation is required.

A more recent report has proposed a transformation of the regulation of all health and social care professionals, making it easier for practitioners to work across professional boundaries (Professional Standards Authority, 2016). This would provide a key opportunity to incorporate the ANP role into a national regulatory system.

If national regulation is to be reconsidered, it would be essential to maintain standards and prevent harm, be clear, address the full scope of practice, and enable flexible roles within the workforce so as not to pose a further barrier to ANP practice (Heale and Rieck Buckley, 2015, Maier, 2015, Professional Standards Authority, 2016).

The next section will address some of the challenges of the current regulatory system in the UK.

Problems with local regulation of the ANP role in the UK

Although the nursing profession has embraced the new challenges of advanced practice, a number of studies have identified problems which may be related to lack of national regulation. Heale and Rieck Buckley (2015) report that a lack of title protection and lack of regulation provide a barrier to ANPs working within their full scope of practice. Others suggest that ANPs experience a lack of standardised educational preparation, organisational constraints, a lack of cooperation of colleagues and lack of freedom to refer and order investigations (Marsden et al., 2003, Pulcini et al., 2010, Barton and Mashlan, 2011, Lloyd-Rees, 2016).

Variation in remuneration has also been identified as a barrier to ANP working. Since 2004, NHS staff in the UK (except doctors, dentists, and senior managers) have been paid according to the Agenda for Change pay scale, guided by a knowledge and skills framework (Department of Health, 1999). The RCN (2012) recommends that a nurse working autonomously as an ANP should be paid at a band 8a. It appears that employers are not always adhering to those guidelines with pay varying from Agenda for Change band 6, to band 8a (Marsden et al., 2013, Fawdon and Adams, 2013). The RCN warns that caution should be taken when applying for ANP jobs as some prospective employers persist in “offering so-called ANP posts for which no specific educational preparation is required, and for which the remuneration on offer is not appropriate for a nurse as competent and highly qualified as an ANP” (Royal College of Nursing, 2012).

Another potential problem with the current procedures is that the process of RCN credentialing is voluntary and will cost nurses a fee every three years (Pearce, 2017) and, as it is in the early stages of implementation the uptake of this service is yet to be evaluated. It may also be unclear for ANPs whether they should credential with the RCN, or one of the specialist medical colleges (currently only offered by RCEM).

Discussion

This paper has outlined the scope of expanded practice of ANPs and the variations in regulation globally and locally. It has highlighted a need for employers and ANPs to take responsibility for their own professional regulation to ensure they are adequately prepared for the roles they are expected to undertake. This process is supported by revalidation (Nursing and Midwifery Council, 2015a), and credentialing

opportunities via medical and nursing colleges (Royal College of Nursing, 2012, Royal College of Emergency Medicine, 2015, Pearce, 2017).

In light of the growing number of ANPs in the UK, and challenges related to local regulation, the nursing profession needs to continually reconsider the most effective mechanism of supporting staff in these roles, and ensuring patient safety.

Employers, clinical managers, and educators have to be responsive to new developments in nursing careers in order to provide the most relevant training and support. Currently in the UK, the burden of responsibility for ANP regulation lies with local employers in primary and secondary care. This review has revealed that, as a result of local governance, there are wide variations in scope and educational preparation of ANPs (Heale and Rieck Buckley, 2015). Ideally employers should adhere to guidelines developed by professional bodies on the appropriate training, pay, working conditions, and support for ANPs. One way that employers and ANPs could do this is to use the new RCN credentialing system (Pearce, 2017), and potentially use it in the future as evidence of fitness to practice and working at ANP level. The NMC Code of Professional Standards (2015b) highlights that ANPs themselves have a responsibility in regulating their practice. Again the RCN credentialing system could be a useful tool for them. However if this joint employer-ANP led governance is not routinely occurring in practice, or is found to be inconsistent, then national regulation by the Nursing and Midwifery Council may need to be reconsidered. The argument to support this is to provide standardised support for nurses, but also an increased understanding of the role by other health professionals, and a greater public awareness of the service provided by ANPs.

The challenge for policy makers, educators and researchers is to identify precisely what types of roles, and skills nurses are currently undertaking in practice, and the best ways to train, and support them. Future research should explore the scope of practice of ANPs in various contexts across the UK, and how consistent current mechanisms of regulation are in different healthcare settings.

Conclusion

After summarising the international literature on the development and support of ANP roles, it is suggested that the increase in implementation of these roles in the UK should be accompanied by sound processes of regulation. There needs to be

effective understanding and sharing of local regulatory procedures by employers. The new system of credentialing may also become a requirement of employers as evidence of ANP level working. This will enhance public protection and ensure adequate preparation for practice. There are also arguments for reconsidering national regulation of the ANP role in the UK, which, in some cases, significantly overlaps with the boundaries of medicine.

Regardless of process, regulation needs to continue to allow for flexibility in meeting the demands of the ever-changing healthcare context, while providing structured training and support for nurses.

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